		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041830

Facility Name: Heartland Health Care Center-Moline

Address: 833 16th Avenue (Number) Moline (City) 61625 (Zip Code)

County: Rock Island

Telephone Number: (309) 764-6744 **Fax #** (309) 764-8176

IDPA ID Number: 344402510012

Date of Initial License for Current Owners: 1966

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419-252-5740)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,874	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,874	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,471	9,521	6,558	21,550	8
9	SNF/PED					9
10	ICF		28,883	17	28,900	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,471	38,404	6,575	50,450	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.17%

D. How many bed-hold days during this year were paid by Public Aid? 8 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/16/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 59 and days of care provided 6,438

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	248,851	16,662	1,759	267,272	2,234	269,506		269,506			1
2	Food Purchase		240,945		240,945		240,945	(2,067)	238,878			2
3	Housekeeping	145,624	14,312	379	160,315		160,315		160,315			3
4	Laundry	69,623	15,406	1,532	86,561		86,561		86,561			4
5	Heat and Other Utilities			151,504	151,504	5,153	156,657	(6,948)	149,709			5
6	Maintenance	40,227	9,311	41,100	90,638		90,638		90,638			6
7	Other (specify):* Medical Waste			597	597		597		597			7
8	**TOTAL General Services**	504,325	296,636	196,871	997,832	7,387	1,005,219	(9,015)	996,204			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	2,032,773	133,150	25,433	2,191,356	38,097	2,229,453		2,229,453			10
10a	Therapy	234,701	2,556	12,696	249,953		249,953		249,953			10a
11	Activities	117,804	9,862	693	128,359		128,359		128,359			11
12	Social Services	100,560	718	586	101,864		101,864		101,864			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,485,838	146,286	49,908	2,682,032	38,097	2,720,129		2,720,129			16
	C. General Administration											
17	Administrative	106,816		299,145	405,961	(299,146)	106,815		106,815			17
18	Directors Fees											18
19	Professional Services			833	833	(21)	812		812			19
20	Dues, Fees, Subscriptions & Promotions			81,905	81,905		81,905	(66,071)	15,834			20
21	Clerical & General Office Expenses	285,901	45,347	52,382	383,630	203,424	587,054	(41,110)	545,944			21
22	Employee Benefits & Payroll Taxes			632,916	632,916	35,025	667,941		667,941			22
23	Inservice Training & Education			3,692	3,692		3,692		3,692			23
24	Travel and Seminar			14,720	14,720		14,720		14,720			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			153,372	153,372		153,372		153,372			26
27	Other (specify):*			678	678		678		678			27
28	**TOTAL General Administration**	392,717	45,347	1,239,643	1,677,707	(60,718)	1,616,989	(107,181)	1,509,808			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,382,880	488,269	1,486,422	5,357,571	(15,234)	5,342,337	(116,196)	5,226,141			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Health Care Center-Moline #0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			389,713	389,713	15,234	404,947		404,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,308	148,308		148,308		148,308			32
33	Real Estate Taxes			94,996	94,996		94,996	20,229	115,225			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,968	24,968		24,968		24,968			35
36	Other (specify):*											36
37	**TOTAL Ownership**			657,985	657,985	15,234	673,219	20,229	693,448			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,461	17,494	195,955		195,955		195,955			39
40	Barber and Beauty Shops			18,392	18,392		18,392		18,392			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,312	76,312		76,312		76,312			42
43	Other (specify):* **Therapy Drugs**		7,421		7,421		7,421		7,421			43
44	**TOTAL Special Cost Centers**		185,882	112,198	298,080		298,080		298,080			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,382,880	674,151	2,256,605	6,313,636		6,313,636	(95,967)	6,217,669			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(530)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,948)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,083)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,457)	21		24
25	Fund Raising, Advertising and Promotional	(2,475)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	20,229	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5a	(67,703)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (95,967)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (95,967)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Health Care Center-Moline

ID# 0041830

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Revenue	$ (1,537)	2	1
2	Late Charges	(95)	21	2
3	Non Allowable Dues	(2,042)	20	3
4	Non Allowable Advertising	(64,029)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,703)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Moline **#** 0041830 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,067)	0	0	0	0	0	0	0	0	0	0	(2,067)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,948)	0	0	0	0	0	0	0	0	0	0	(6,948)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,015)	0	0	0	0	0	0	0	0	0	0	(9,015)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(66,071)	0	0	0	0	0	0	0	0	0	0	(66,071)	20
21	Clerical & General Office Expenses	(41,110)	0	0	0	0	0	0	0	0	0	0	(41,110)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(107,181)	0	0	0	0	0	0	0	0	0	0	(107,181)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,196)	0	0	0	0	0	0	0	0	0	0	(116,196)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heartland Health Care Center-Moline **#** 0041830 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	20,229	0	0	0	0	0	0	0	0	0	0	20,229	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	20,229	0	0	0	0	0	0	0	0	0	0	20,229	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,967)	0	0	0	0	0	0	0	0	0	0	(95,967)	45

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp.	Toledo, Ohio			
		of America				
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 299,145	HCR Manor Care, Inc.	100.00%	$ 299,145	$	1
2	V	Page							2
3	V	e							3
4	V								4
5	V								5
6	V	10a	Therapy Management	12,450	Heartland Management Services	100.00%	12,450		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 311,595			$ 311,595	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: (419-252-5500)
Fax Number: (419-252-5495)

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	$	$	6,057,408	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	6,057,408	2,234	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		6,057,408	573	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		6,057,408	4,580	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	6,057,408	33,275	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	6,057,408	4,822	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	6,057,408	42,560	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	6,057,408	160,843	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		6,057,408	10,055	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		6,057,408	24,970	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.			6,057,408	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		6,057,408	15,234	12
13										13
14	32	Interest				10,002,527				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 299,146	25

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank, Trustee		x	Purchase Facility		Oct/91	$ 389,893	$ 389,893			$ 148,308	1
2	National City Bank, Trustee		x	Finance Capital Additions		3/97&11/97	972,504	972,504				2
3	National City Bank, Trustee		x	Finance Capital Additions		6/01&9/01	1,010,547	1,010,547				3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,372,944	$ 2,372,944			$ 148,308	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,372,944	$ 2,372,944			$ 148,308	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	74,767	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	94,996	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,229	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	94,996	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	115,225	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	78,933	8
2000	81,446	9
2001	107,537	10
2002	91,152	11
2003	74,767	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0041830

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-533-28-00	See Attached	$ 23,749.09	$ 23,749.09
2.	08-533-28-00	See Attached	$ 23,749.09	$ 23,749.09
3.	08-533-28-00	See Attached	$ 23,749.09	$ 23,749.09
4.	08-533-28-00	See Attached	$ 23,749.09	$ 23,749.09
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 94,996.36	$ 94,996.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,321 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N\A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983	$ 74,186	1
2			1996	106,824	2
3	TOTALS			$ 181,010	3

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1966	1966	$ 1,033,964	$ 94,200	30	$ 94,200	$	$ 1,683,446	4
5				1983	56,519		5				5
6	10			1998	1,398,475		10-20				6
7	10			2001	709,498		40				7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					177,269		177,269		1,568,039	9
10	Leasehold Improvements			1971	26,975						10
11	Leasehold Improvements			1972	1,481						11
12	Leasehold Improvements			1973	2,593						12
13	Leasehold Improvements			1974	271						13
14	Leasehold Improvements			1975	4,140						14
15	Leasehold Improvements			1976	16,237						15
16	Leasehold Improvements			1977	10,225						16
17	Leasehold Improvements			1978	5,160						17
18	Leasehold Improvements			1981	28,386						18
19	Leasehold Improvements			1982	14,373						19
20	Leasehold Improvements			1983	22,737						20
21	Leasehold Improvements			1984	5,789						21
22	Land Improvements			1985	1,470						22
23	Building Improvements			1985	109,949						23
24	Building Improvements			1986	25,262						24
25	Building Improvements			1987	16,145						25
26	Land Improvements			1987	707						26
27	Building Improvements			1988	204,870						27
28	Building Improvements			1989	3,273						28
29	Building Improvements			1990	22,292						29
30	Building Improvements			1991	8,230						30
31	Land Improvements			1991	4,771						31
32	Building Improvements			1992	16,985						32
33	Building Improvements			1993	21,450						33
34	Building Improvements			1994	51,438						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Land Improvements	1995	980						38
39	Building Improvements	1995	32,598						39
40	Land Improvements: Sign, Landscatping, and Concrete Bumpers	1996	25,027						40
41	Building Improvements: Painting/Wallcovering, Carpet, Paging system,	1996	126,134						41
42	doors/fixtures,millwork,air conditioning, moving/storage, cabinets,								42
43	hand rails,electrical wiring, ceramic tile, and bathroom sinks								43
44	Building Improvements: Fire alarm	1996	45,151						44
45	Building Improvements: Intercom system	1996	27,230						45
46	Building Improvements: Renovation of lobby, foyer, busines office:	1996	94,414						46
47	architect and engineering fees, interior design costs, drywall and								47
48	corner guards, aluminum chips, electrical heating, air conditioning								48
49	fire stop installation and access doors, and storage fees								49
50	Building Improvements: Wallcovering	1996	118,024						50
51	Building Improvements: Sewer Runs	1997	10,708						51
52	Building Improvements: Wallcovering, Floor Carpet, Cabinets,	1997	120,159						52
53	door frames, millwork, carpetry, caulking, ceilings plaster,								53
54	plumbing comosite, electrical composite, sinks, conduit wiring,								54
55	door closing devices, nurses call system								55
56	Building Improvements: 18 Bed Addition, wallcovering, conncrete,	1997	334,930						56
57	doors wood, telephone system, fencing wire, electrical transformer,								57
58	HVAC, hollow metal doors, duct work								58
59	Building Improvements: Install HVAC, electrical composite	1997	291,760						59
60	Building Improvements: Roof Replacement	1997	49,483						60
61	Building Improvements: Door	1997	1,042						61
62	Building Improvements: Siding on new additon	1997	4,993						62
63	Building Improvement: VWC from Inventory	1997	1,464						63
64	Land Improvements: Sign	1997	593						64
65	Land Improvements: Landscaping	1997	801						65
66	Land Improvements: Fence	1997	5,422						66
67	Bldg. Improvements: Cupola	1998	5,440						67
68	Bldg. Improvements: HVAC	1998	23,069						68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,143,087	$ 271,469		$ 271,469	$	$ 3,251,485	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,143,087	$ 271,469		$ 271,469	$	$ 3,251,485	1
2									2
3	Bldg. Improvements: Roof	1998	8,203						3
4	Bldg. Improvements: Electrical Work for Renovation	1998	32,459						4
5	Bldg. Improvements: Add't HVAC	1998	15,464						5
6	Bldg. Improvements: 8 Bed Addition	1998	88,423						6
7	Building Improvements: Light Fixtures for Nurses Station	1998	2,211						7
8	Land Improvements: Grading	1998	1,779						8
9	Bldg. Improvements: Wall covering, charting system, compressor	1998	35,511						9
10	Bldg. Improvements: Doors	1998	10,151						10
11	Asphalt Work	1999	14,164						11
12	Smoking Shelter	1999	5,254						12
13	Overhead from Const	1999	29,447						13
14	Concrete Pad for Smoking	1999	924						14
15	Exit Device	1999	474						15
16	Carpet	1999	994						16
17	Carpet	1999	553						17
18	Awning	1999	2,788						18
19	Building Decorations	1999	653						19
20	Retainage for Carpet	1999	73						20
21	Retainage Fee for Carpet	1999	59						21
22	Wallboard	1999	568						22
23	Wiring	1999	3,850						23
24	Wall, Drain Lines, Electrica	1999	15,776						24
25	Boiler Pump	2000	5,433						25
26	HVAC Upgrade	2000	1,600						26
27	Boiler room exhuast	2000	5,684						27
28	Phone line	2000	800						28
29	Phone line	2000	800						29
30	Ceramic tile	2000	511						30
31	Carpet	2000	842						31
32	Sinks & faucet	2000	1,055						32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,429,588	$ 271,469		$ 271,469	$	$ 3,251,485	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,429,588	$ 271,469		$ 271,469	$	$ 3,251,485	1
2									2
3	Addt'l cost sinks	2000	218						3
4	Addt'l cost carpeting	2000	59						4
5	Addt'l cost carpet	2000	94						5
6	Retainer on boiler room exhaust	2000	632						6
7	Replace door in laundry	2000	4,932						7
8	Bldg Imprv - Carpentry/Wallcovering	2001	11,535						8
9	Bldg Imprv - Carpentry/Electrical	2001	60,645						9
10	Bldg Imprv - Wallcovering	2001	11,630						10
11	Land Imprv - Concrete work	2001	4,941						11
12	Land Imprv - Walkway & Canopy	2001	3,858						12
13	Wire Component Connection	2001	2,543						13
14	Wire Component Connection	2002	327						14
15	Wire Component Connection	2002	402						15
16	Building Addition - VWC - Corridor	2002	19,847						16
17	Paint, VWC - Corridor Renovation	2001	45,377						17
18	Corner Guards	2002	7,153						18
19	Mini-Edger	2002	729						19
20	Corner Guards - Asset adjustment	2002	(4,953)						20
21	Building Addition - Paving/Landscaping	2002	8,679						21
22	Building Addition - Paving/Landscaping	2002	8,397						22
23	Building Addition - Paving/Landscaping	2002	111,907						23
24	Paving	2002	5,025						24
25	2 Dell celeron	2002	1,687						25
26	Electrical Work Overhead & Interest	2003	55,146						26
27	Overhead & Interest	2003	8,734						27
28	General Construction	2003	5,540						28
29	Carpet and Flooring	2003	83,248						29
30	Floorcovering	2003	702						30
31	Floorcovering	2003	251						31
32	HVAC	2003	7,643						32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,896,514	$ 271,469		$ 271,469	$	$ 3,251,485	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,896,514	$ 271,469		$ 271,469	$	$ 3,251,485	1
2									2
3	HVAC Kitchen retainage	2003	5,627						3
4	Overhead & Interest	2003	8,231						4
5	HVAC	2003	84,377						5
6	Retro Cost Adjustment	2003	48,938						6
7	Sealcoat & Restripe Pkg.	2004	2,602						7
8	VWC	2004	68						8
9	Flooring and Painting	2004	1,486						9
10	VWC & Painting	2004	1,278						10
11	Carpet	2004	472						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,049,593	$ 271,469		$ 271,469	$	$ 3,251,485	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,646,868	$ 118,244	$ 118,244	$		$ 1,278,919	71
72	Current Year Purchases	69,124						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			15,234	15,234			74
75	TOTALS	$ 1,715,992	$ 118,244	$ 133,478	$ 15,234		$ 1,278,919	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van With		$ 22,049	$	$	$		$ 22,049	76
77		Chair Lift								77
78										78
79										79
80	TOTALS			$ 22,049	$	$	$		$ 22,049	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,968,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 389,713	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 404,947	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,234	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,552,453	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 24,968 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2724 hrs	$ 64,994	121	$ 3,037	$ 281	2,845	$ 68,312	1
2	Licensed Speech and Language Development Therapist	10a	767 hrs	18,293	50	1,241	29	817	19,563	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	6346 hrs	151,414	337	8,418	2,246	6,683	162,078	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				178,461		178,461	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S X-Ray & Lab	10a,39,Col.3				17,494			17,494	13
14	TOTAL			$ 234,701	508	$ 30,190	$ 181,017	10,345	$ 445,908	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,238	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (109,474))	652,927		3
4	Supply Inventory (priced at)	32,704		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	695		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 687,564	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,010		13
14	Buildings, at Historical Cost	5,909,540		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,878,094		16
17	Accumulated Depreciation (book methods)	(4,552,453)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	110,633		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,526,824	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,214,388	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,536	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	347,163		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	94,996		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	46,142		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 535,837	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,372,944		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	26,397		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,399,341	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,935,178	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,279,210	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,214,388	$	48

***(See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,305,060	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,305,060	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,578,445	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,578,445	17
	B. Transfers (Itemize):		
18		(2,604,295)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,604,295)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,279,210	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,207,823	1
2	Discounts and Allowances for all Levels	(316,470)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,891,353	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	774,837	6
7	Oxygen	15,875	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 790,712	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,620	12
13	Barber and Beauty Care	23,247	13
14	Non-Patient Meals	530	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,701	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,272	19
20	Radiology and X-Ray	6,843	20
21	Other Medical Services	5,233	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 207,446	23
	D. Non-Operating Revenue		
24	Contributions	2,475	24
25	Interest and Other Investment Income***	95	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,570	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,892,081	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	997,832	31
32	Health Care	2,682,032	32
33	General Administration	1,677,707	33
	B. Capital Expense		
34	Ownership	657,985	34
	C. Ancillary Expense		
35	Special Cost Centers	298,080	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,313,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,578,445	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,578,445	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,822	2,004	$ 57,303	$ 28.59	1
2	Assistant Director of Nursing	1,924	2,116	48,572	22.95	2
3	Registered Nurses	13,100	14,407	284,186	19.73	3
4	Licensed Practical Nurses	28,655	31,516	491,120	15.58	4
5	Nurse Aides & Orderlies	101,798	111,962	1,114,706	9.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,949	9,835	234,701	23.86	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,365	11,399	117,804	10.33	10
11	Social Service Workers	5,863	6,450	100,560	15.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,949	28,540	248,851	8.72	15
16	Dishwashers					16
17	Maintenance Workers	1,993	2,193	40,227	18.34	17
18	Housekeepers	16,336	17,967	145,624	8.11	18
19	Laundry	6,772	7,451	69,623	9.34	19
20	Administrator	2,828	2,828	106,816	37.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,621	10,225	160,229	15.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,929	2,121	36,886	17.39	31
32	Other Health C: Hospitality	7,407	8,153	93,812	11.51	32
33	Other(specify) Human Resources	1,897	1,897	31,860	16.79	33
34	TOTAL (lines 1 - 33)	246,208	271,064	$ 3,382,880 *	$ 12.48	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	10,500	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,500		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vicki Toomsen	Administrator	0	$ 106,816
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,816

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 299,145
TOTAL (agree to Schedule V, line 17, col. 3)	$ 299,145
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Katz, Huntoon & Fieweger, P.C.	Legal	$ 287
Andich & Andich	Legal	600
Rossman & Co.	Acctg. Fees	21
Accrual		(75)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 833

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,817
Unemployment Compensation Insurance	50,117
FICA Taxes	242,711
Employee Health Insurance	301,389
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	5,025
401K	14,496
Other Empl Benefits	33
Emp Vac & Uniform	2,731
SMSPMatch	2,598
P/R O/H	(1)
Home Office Allocation	35,025
TOTAL (agree to Schedule V, line 22, col.8)	$ 667,941

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,065
Advertising: Employee Recruitment	3,231
Health Care Worker Background Check	3,447
(Indicate # of checks performed 138)	
Association Dues	4,384
NDAssocD	2,041
Advertising Allowable	3,708
Advertising Non-Allowable	64,029
Less: Lobbying Expense	(2,042)
Less: Public Relations Expense	( )
Non-allowable advertising	(64,029)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,834

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14,720
Includes travel expenses to the home	
office in Toledo, Ohio for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,720

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Health Care Center-Moline # 0041830 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland Health Care Center-Moline **#** 0041830 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6,425**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **$2,042**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,850** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,312**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **530**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.